CENTERS FOR MEDICARE & MEDICAID SERVICES

10/06/2011 PRINTED: FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155685		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION  01	l' '	TE SURVEY  IPLETED  1/2011		
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-ELKHART			STREET ADDRESS, CITY, STATE, ZIP CODE  1001 W HIVELY AVENUE  ELKHART, IN46517					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
K0000	and State Licer conducted by to Department of with 42 CFR 4 Survey Date:  Facility Numb Provider Number:  Surveyor: Rice Safety Code Seafety Code (National Fire In Association (Nafety Code (In Safety Code (In Sa	er: 000039 ber: 155685 100275130 hard D. Schade, Life pecialist  fety Code survey, Center-Elkhart was ompliance with for Participation in licaid, 42 CFR 0(a), Life Safety from 000 edition of the Protection IFPA) 101, Life LSC), Chapter 19, h Care Occupancies	K	0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UMQ421

Facility ID:

000039

TITLE

If continuation sheet

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		155685	B. WIN			09/20/2	011
NAME OF PROVIDER OR SUPPLIER				1001 W	ADDRESS, CITY, STATE, ZIP CODE  HIVELY AVENUE	•	
	I LIVING CENTER-E				RT, IN46517		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
K0038	This one story determined to construction are sprinklered. To (North, East are constructed in addition (Primal wings) built in has a fire alarm detection in the spaces open to facility has a chad a census of this survey.  Quality Review by Forced Specialist-Medical Compliance with a forcemental and a following:	facility was be of Type V (111) and was fully the original building and South wings) was 1968 with an rose and Southwest 1975. The facility an system with smoke the corridors and the corridors. The apacity of 175 and apacity of 175 and apacity of 175 and f 152 at the time of  Robert Booher, Life Safety dical Surveyor on 09/23/11.					
SS=E		at all times in accordance 19.2.1					

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´		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILI	DING	01	COMPL		
155685		B. WING			09/20/20	011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVING CENTER-	ELKHART			' HIVELY AVENUE RT, IN46517		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	17.00	TAG	K-38		DATE
	Based on obse		K00	J38	1. The concrete sidewalk has b	oeen	10/20/2011
	ŕ	facility failed to			replaced at the main entrance of the facility and there were no		
	ensure exit egr	ress for 1 of 27 exits					
	was arranged t	to minimize tripping			residents affected by this alleg deficient practice.	ea	
	hazards in acc	ordance with LSC			2. Residents, staff and visitors		
	Section 7.1. L	SC Section 7.1			residing at the facility have th		
	requires that m	neans of egress for			potential to be affected by the alleged deficient practice		
	existing buildi	ngs shall comply			3. Environmental/Life Safety		
	_	7. LSC Section 7.1.6			Rounds which will include exi		
	requires walking surfaces in the				egresses will be completed on monthly basis to ensure any	a	
	•	ss shall comply with			changes in exterior surfaces a	re	
	_	h 7.1.6.4. LSC			corrected or repaired as neede	ed.	
	•	2 requires abrupt		4. Environmental/Life Safety inspection reports will be forwarded to the QA&A committee for review The results			
	_	vation shall not					
		h. LSC Section			of these audits will be reported the Director of Maintenance e	- 1	
	_	es walking surfaces to			6 months and then the QAA to		
	be nominally level. LSC Section				will determine the need for		
	7.1.6.4 require	es walking surfaces to			additional auditing until a threshold of 100% is achieved		
	be slip resistar	nt under foreseeable			threshold of 100% is achieved		
	conditions. Th	nis deficient practice					
	could affect an	ny residents, staff and					
		the main entrance					
	exit.						
	Findings inclu	de:					
	Based on obse	rvation with the					
	maintenance s	upervisor on					
		00 p.m., the concrete					
	55,=0,11 <b>ut</b> 1.0	p.i.i., the concrete					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY  COMPLETED
		155685	B. WING		09/20/2011
NAME OF I	PROVIDER OR SUPPLIER		ı	ADDRESS, CITY, STATE, ZIP CODE  WHIVELY AVENUE	
GOLDEN	I LIVING CENTER-			ART, IN46517	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0062 SS=E	exit had seven inches in width with a depth of cracks. The m supervisor stat wanting to corthe last three y 3.1-19(b)  Required automatic continuously main condition and are in periodically. 19. 25, 9.7.5  Based on obserview, the replace 2 of 2 inservice training painted. LSC automatic spring inspected, tested accordance with for the Inspect Maintenance of the service of the ser	ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA	K0062	1. The two automatic sprinkle heads were replaced by the Maintenance Director. There no residents affected by the all deficient practice.  2. Residents' residing at the facility have to potential to be affected by the alleged deficien practice.  3. The Maintenance Director perform environmental/life sarounds which will include sprinkler heads on a monthly basis.  4. Environmental/Life Safety inspection reports will be	were leged nt will fety

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL  A. BUILDING  B. WING	E CONSTRUCTION  01	COM	TE SURVEY IPLETED 1/2011	
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-ELKHART			STRE 100	EET ADDRESS, CITY, STATE, ZI 11 W HIVELY AVENUE KHART, IN46517	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	1998 edition, 2 sprinkler shall painted, corrod loaded, or in the orientation. To could effect the inservice train.  Findings inclusion Based on obsessive with the mainted of 19/20/11 at 3:2 automatic spring inservice train painted. The resupervisor states.	2-2.1.1 requires any be replaced which is ded, damaged, ne improper his deficient practice e staff in and near the ing room.  de:  rvation during a tour enance supervisor on 20 p.m., the two nklers in the ing room were		forwarded to the Q committee for revie of these audits will the Director of Mai monthly for 6 mont QAA team will dete for additional audit threshold of 100%	ew. The results be reported by intenance ths and then the ermine the need ting until a	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155685		A. BUILDING  R. WING			(X3) DATE SURVEY COMPLETED 09/20/2011		
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-ELKHART			B. WING				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0076 SS=E	are protected in ad Standards for Head (a) Oxygen storagy 3,000 cu.ft. are en separation.  (b) Locations for sethan 3,000 cu.ft. and NFPA 99 4.3.1.1.2 Based on obsetinterview, the ensure 3 of 4 corooms were seconstruction were sistant rating 8-3.1.11.1 requiremental requiremental requiremental requiremental registration of the provided for oxidizing agent This deficient facility's corriemental requiremental registration.  Findings inclusions for sething and visitors.	e locations of greater than closed by a one-hour  upply systems of greater re vented to the outside.  19.3.2.4  rvation and facility failed to exygen supply storage parated by eith a one hour fire gases shall comply  NFPA 99, equires at least one ant enclosures shall r the storage of tts such as oxygen. practice affects the lors where resident ted including staff	K	0076	1. The Oxygen Room Doors have replaced and have the appropriate fire rating. 2. Residents' residing at the fa have the potential to be affected the alleged deficient practice. 3. Enviornmental/Life Safety rounds which will include Oxystorage rooms will be perform by the Director of Maintenance a monthly basis and changes is door structure will be repaired needed. 4. Environmental/Life Safety inspection reports will be forwarded the QA&A commit monthly for 6 months and the QAA committee will determin need for additional auditing uthreshold of 100% is achieved	cility ed by  gen ed e on n l as tee n the e the ntil a	10/20/2011

000039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155685		A. BUII	LDING	NSTRUCTION  01	(X3) DATE COMPL	ETED		
NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-ELKHART			B. WING 09/20/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  1001 W HIVELY AVENUE  ELKHART, IN46517					
	summary s (EACH DEFICIEN REGULATORY OR  of the facility s supervisor on 2:10 p.m. and to the oxygen South, Southw separating the adjacent exit c the required 4: and tag as evic fire rating. Ea room containe containers and oxygen gas ca maintenance s the time of the certain the oxy doors were rat	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) with the maintenance 09/20/11 between 3:50 p.m., the doors storage rooms for the rest and East wings, area from the orridor, did not have 5 minute fire rating dence of the doors' ch oxygen storage d liquid oxygen various smaller		1001 W	HIVELY AVENUE	NTE	(X5) COMPLETION DATE	